Virginia PACE

Overview

The Program of All-Inclusive Care for the Elderly (PACE) was established to assist qualifying adults, age 55 and over, to remain living in their homes. The PACE program allows individuals to remain in familiar surroundings, maintain self-sufficiency and preserve the highest level of physical, social and cognitive function and independence. The goal of PACE is to keep the adult individual in their homes and communities and provide the entire continuum of medical and supportive services as needed.

Philosophy

The Program of All-inclusive Care for the Elderly (PACE) is centered on the belief that it is best for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible.

PACE services are all coordinated through an inter-disciplinary team (IDT) with the full involvement of the individual and their family/ significant other. Services are designed and delivered in a personal manner taking care of the individual's complete medical and supportive care.

Eligibility

An Individual must have all of the following in order to meet criteria for enrollment into PACE:

1. Must have Medicaid and/or Medicare separately or together;
2. Be 55 years of age or older;
3. Reside in the PACE organization service area;
4. Meet any additional program eligibility conditions required under the PACE program agreement; and
5. At the time of enrollment, an individual must be assured that they can live safely in the community.

To be eligible for PACE, an individual must be pre-screened by a pre-admission screening team, using the Virginia Uniform Assessment Instrument (UAI). There are three sources for obtaining this screening. They are: the local Department of Social Services and the local Department of Health, or a Hospital from which the individual is being discharged.

Services

The PACE program is able to provide the entire continuum of care and PACE services to seniors with chronic care needs while maintaining their independence in their homes for as long as possible. This network of service delivery is guided by federal and state regulations that require a comprehensive range of PACE services.

The interdisciplinary team (IDT) coordinates with the PACE participant services medically needed and/ or requested. The IDT team consists of specialists who arrange for/ or provide services through the PACE program. As required in both federal and state regulations, the PACE organization's IDT is comprised of the following members who have a minimum of one year's experience working with the elderly population:

Primary Care Physician
Registered Nurse
Nurse Practitioner (Optional)
Dietitian
Recreational Therapist or Activity Coordinator
Home Care Coordinator

Masters Level Social Worker	Personal Care Attendant
Physical Therapist	PACE Site Manager
Occupational Therapist	Transportation - Van Driver

Services

The IDT comprehensively assess the PACE participant to ensure their individual needs are met. PACE services include all Medicare and Medicaid covered items and services as well as other services determined necessary by the IDT to improve and maintain the PACE participant's overall health status while living safely in the community,

Payments for Services

PACE is a capitated, single payment benefit program that provides a comprehensive service delivery system and features integrated Medicare and Medicaid financing.

As early as 2007 with the first PACE program in Virginia Beach, Sentara PACE and reaching as Far Southwest as Big Stone Gap, Mountain Empire Older Citizens PACE, Virginia is successfully operating 12 PACE sites, has 8 PACE providers.